

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

-63-013661

STATE FILE NUMBER

2932

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

VS 300
Rev. 4/59

1

2

3

4

5

6

7

8

9

10

11

12

13

DATE AMENDED
INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

SHOULD READ

1. PLACE OF DEATH a. COUNTY St. Louis FILED MAR 21 1963		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) Deaconess Hospital		d. STREET ADDRESS (If outside, give location) 6518 Clayton Ave.	
3. NAME OF DECEASED (Type or print) First SOPHIA Middle NISIANKAS Last		4. DATE OF DEATH Month March Day 10 Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-20-1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		11. BIRTHPLACE (City and state or country) Greece	
13a. FATHER'S NAME Nicholaus Stamulis		14. NAME OF HUSBAND OR WIFE Vasilios Nisiankas	
15. WAS DECEASED EVER IN U.S. ARMED FORCE (Yes, no, or unknown) (If yes, give war or dates) No		17. INFORMANT Vasilios Nisiankas 6518 Clayton Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction - Anterior DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 4200			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Thyroiditis, Corbin Drugging, Encephalomalacia due to Cerebral Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour 6:30 a.m. p.m. Month, Day, Year 3/5/63		20f. CITY, TOWN, OR LOCATION St. Louis, Mo.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. I attended the deceased from 3/5/63 to 3/10/63 and last saw her alive on 3/10/63 Death occurred at 6:30 P. m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Robert H. Ramsey, M.D.		22b. ADDRESS 119 Church St. Ferguson 35, Mo	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar. 13, 1963	
23c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway Blvd.		25. DATE RECD. BY LOCAL REG. MAR 13 1963	
		26. REGISTRAR'S SIGNATURE Loan Smith, M.D.	

Dr. Robert Ramsey Ja. 4-0560
119 Church St.-Ferguson 1:30-6 Tue.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Ernest W. Willard
Licensed Embalmer No. 4080

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.